STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Notice Public Meeting

Pursuant to T.C.A. § 33-1-309

In accordance with § 33-1-309 of the *Tennessee Code Annotated a Public Meeting will be held to receive comments on the Department of Intellectual and Developmental Disabilities Policies and Procedures " Authorization of Services" and "Sanction Policy", a copy of which is attached hereto.*

This Public Meeting will be held on ***Monday, October 29, 2012 from 1:00 to 3:00 p.m.*** in the ***Large Conference Room on the Ground Floor of One Cannon Way, Clover Bottom Developmental Center Campus, One Cannon Way, Nashville, Tennessee 37214.***

STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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Nashville, Tennessee 37243

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Public Meeting Under Tennessee Code Annotated 33-1-309

October 29, 2012 @ 1:00 p.m.
One Cannon Way Drive, Clover Bottom Developmental Center Campus
275 Stewart's Ferry Pike, Nashville, TN 37217

WRITTEN COMMENT FORM

PLEASE RETURN BY November 5, 2012
Email: linda.sharer@tn.gov or fax: 615-532-9940

Date: _____

Name: _____
(Please Print)

Organization (if applicable): _____

Address: _____

Email: _____ **Phone:** _____

TOPIC: (If you wish to comment on more than one topic, please submit a separate comment sheet for each topic)

1. **Changes to Policies and Procedures "Authorization of Services"**
2. **Changes to Policies and Procedures "Sanction Policy"**

My Comment:

_____

Signature

POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #: 80.3.4	Page 1 of 5
Policy Type: Community / Waiver	Effective Date:	
Approved by: Commissioner	Supersedes: N/A Last Review or Revision: N/A	
Subject: Authorization of Services		

I. **AUTHORITY:** 42 CFR 441.301(b) (1) (i), Bureau of TennCare Rules Chapter 1200-13-01; TennCare Medical Necessity Protocols, Tennessee Code Annotated 4-3-2708, Tennessee Code Annotated 71-5-144, Tennessee Home and Community Based Waivers.

Comment [JCM1]: Corrected.

Comment [CWG2]: This TCA seems to be incorrect

II. **PURPOSE:** The purpose of this policy is to establish guidelines for review and approval of Individual Support Plans (ISP), amendments, covered waiver services and state funded individuals.

III. **APPLICATION:** This policy applies to all Department of Intellectual and Developmental Disabilities (DIDD) staff responsible for reviewing and approving independent support plans (ISP) and amendments, covered waiver services, and state funded individuals; state Case Managers (CM), Independent Support Coordination (ISC) agencies; and approved providers of waiver services.

IV. **DEFINITIONS:**

A. **Adverse Action Affecting TennCare Services or Benefits** as it relates to actions under the Grier Revised Consent Decree shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits, as well as any other act or omission of the TennCare program, which impairs the quality, timeliness, or availability of such services.

Comment [CWG3]: This term is not used in the policy. I have recommended that it be used in D.2

Comment [JCM4R3]: It's used in D.1.

B. **Appeals Unit** shall mean the departmental unit responsible for issuing notices of any adverse action to persons-supported by the department.

C. **Bureau of TennCare or TennCare** shall mean the single state Medicaid agency that is responsible for the administration of the state's Medicaid program.

D. **Covered Services or Covered Waiver Services** shall mean services which are available through Tennessee's Home and Community Based Services Waiver, when medically necessary, and when provided in accordance with the waiver as approved by the Centers for Medicare and Medicaid Services.

E. **Enrollee** shall mean a Medicaid enrollee who is enrolled in a Home and Community Based Services waiver.

F. **Home and Community Based Services (HCBS) waiver or Waiver** shall mean a waiver approved for Tennessee by the Centers for Medicare and Medicaid Services, to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability, and who meet criteria for Medicaid reimbursement in an Intermediate Care Facility for People with Intellectual Disabilities. The HCBS waivers for people with intellectual disabilities in Tennessee are operated by the Department of Intellectual and Developmental Disabilities with oversight from TennCare, the state Medicaid agency.

G. **Independent Support Coordinator (ISC) or Case Manager (CM)** shall mean a person who provides support coordination services to an enrollee; who is responsible for developing, monitoring, and assuring the implementation of the Plan of Care; who assists the enrollee in identifying, selecting, obtaining, coordinating, and using both paid services and natural supports to enhance the enrollee's independence, integration in the community, and productivity as specified in the ISP.

H. **Individual Support Plan (ISP)** shall mean a person-centered document that provides an individualized comprehensive description of the person-supported, as well as, guidance for achieving unique outcomes that are important to the person in achieving a good quality of life in the setting in which they reside.

Comment [CWG5]: This definition is not the same as the one in the Provider Manual

Comment [JCM6R5]: Already discussed.

I. **Medical Item or Service** shall mean an item or service that is provided, ordered, or prescribed by a licensed health care provider, and is primarily intended for a medical and or behavioral purpose.

J. **Medical Necessity** shall mean the quality of being "medically necessary" as defined by Tennessee Code Annotated 71-5-144 and applies to TennCare enrollees.

K. **Medical Necessity Determination** shall mean a decision made by the department's Director of Health Services or Plans Review Unit regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Tennessee Code Annotated 71-5-144, and satisfies the definition of services specified in the approved waiver, otherwise not available to enrollees under the approved Medicaid state plan.

L. **Medical Necessity Protocols** shall mean guidelines approved by the TennCare Chief of Long Term Services and Supports or designee and the department's Director of Health Services for the purpose of guiding medical necessity determinations.

M. **Medically Necessary** shall mean medical items and services as defined in Tennessee Code Annotated 71-5-144. No enrollee shall be entitled to receive and the department shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services as defined in this statute or the approved waiver.

Comment [CWG7]: This definition is not the same as in the Provider Manual

Comment [JCM8R7]: Already discussed.

N. **Plan of Care** shall mean the Individual Support Plan.

O. **Plans Review Unit** shall mean the departmental unit responsible for reviewing individual support plans (ISP) in accordance with approved medical necessity protocols to pre-authorize or deny covered waiver services.

P. **Section C** shall mean the part of the ISP that details the projected annual amount, frequency, and duration of waiver services.

V. **POLICY:** The department ensures the health and welfare of enrollees through review and approval of the Individual Support Plan. The department authorizes ISPs that are person-centered, i.e., identifies services and supports important to and for the person-supported, reflects the choices and desires of the person-supported, as well as, the outcomes the person has chosen to achieve. The department authorizes covered waiver services that are medically necessary. Medical items or services that are not medically necessary shall not be paid for by the department.

VI. **PROCEDURES:**

A. Individual Support Plan Review

1. All waiver services for an enrollee shall be provided in accordance with an approved Individual Support Plan. The department reviews and approves all ISPs to ensure that covered waiver services are authorized prior to payment.

2. Prior to development of the initial ISP, covered services shall be provided in accordance with the physician's initial plan of care section of the Pre-Admission Evaluation (PAE) application.

3. Each enrollee shall have a comprehensive individualized written ISP that shall be developed within sixty (60) calendar days of the enrollee's admission to the waiver.

4. Where required by state law, covered services shall be ordered or reordered by a licensed physician, nurse practitioner, physician assistant, dentist, or other appropriate healthcare provider.

5. The ISC / CM shall review the ISP when needed, but no less frequently than once each calendar month, and shall document each review on the Support Coordination/Case Management Monthly Documentation Form with a dated signature.

6. The ISC / CM is responsible for ensuring that the ISP is amended (i.e., updated or revised) when warranted by changes in the needs of the person-supported.

   a. A team consisting of the ISC / CM and other appropriate participants in the development of the ISP shall review the ISP when needed, but no less frequently than once every twelve (12) calendar months, and shall document such review on the Annual ISP Review and Update Documentation Form with dated signatures.

   b. The ISC / CM shall submit the ISP with amendments or the annual ISP to the department Plans Review Unit.

   c. The Plans Review Unit shall review and approve amended and annual ISPs when needed, but no less frequently than once every twelve (12) calendar months, and shall document such review with dated signatures.

Comment [JCM9]: Do not concur because the rule is referenced in the authority section.

Comment [CWG10]: Since you reference the TennCare Rules, you should probably use the content of the Rule for this section

Comment [CWG11]: If you are using Attachment D for this requirement, you will need to update the form for Monthly documentation.

Comment [JCM12]: Listed in section VII.

B. Medical Necessity Determinations

1. Covered services are authorized in accordance with the approved waiver definitions and in accordance with the medical necessity protocols.

2. Waiver enrollees are eligible to receive, and the department shall provide payment for, only those medical items and services that are:

   a. Within the scope of benefits defined in the waiver.

   b. Determined by the department to be medically necessary.

3. The Plans Review Unit consistently and reliably applies the medical necessity protocols in order to make medical necessity determinations prior to authorizing covered waiver services.

C. Approval of Annual ISPs and ISP Amendments

1. The person-supported, ISC/CM, and other appropriate participants shall develop the ISP and any amendments.

2. The ISC/CM shall submit the ISP to the department regional office at least sixty (60) calendar days prior to the effective date of the new or amended ISP.

3. At any time, the ISC/CM acting on behalf of the person-supported may send an amended ISP to the department regional office.

4. The Plans Review Unit shall review the ISP and amendments in accordance with the approved waiver definitions and medical necessity protocols.

   a. The Plans Review Unit shall complete the protocol checklist for each medical item or service requested on the ISP or amendment.

   b. The Plans Review Unit shall determine the medical necessity of medical items and services within fourteen (14) calendar days of receipt of the ISP.

   c. All medically necessary items and services shall be approved. The plans reviewer's signature on the ISP section C shall serve as evidence that the requested medical items and services were authorized. A copy of the ISP section C shall be transmitted to the ISC/CM and provider(s).

D. Appeals

1. The appeals unit may partially approve or deny requests for medical items and services. The appeals unit shall notify the enrollee or legal representative, the ISC/CM, and service providers of any adverse action in accordance with the Grier Revised Consent Decree.

2. Upon an adverse action affecting TennCare Services or Benefits all enrollees are afforded advance notice, the right to appeal an adverse decision, and the opportunity to have a fair hearing in accordance with requirements of the Grier Revised Consent Decree

VII. **ATTACHMENTS**:

A. Attachment #1: Individual Support Plan
B. Attachment #2: Provider's Supporting Documentation Form
C. Attachment #3: Caregiver's Supporting Documentation Form
D. Attachment #4: Annual ISP Review and Update Documentation Form
E. Attachment #5: Support Coordination/Case Management Monthly Documentation Form

POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #:	Page 1 of 5
Policy Type: Community	**Effective Date:**	
Approved by: Commissioner	**Supersedes:** P-003 Recoupment and Sanction Policy	
	Last Review or Revision: June 11, 2012	
Subject: Sanction Policy		

I. **AUTHORITY:** Provider Agreement, Tennessee Code Annotated 4-3-2708; Tennessee Code Annotated 33-1-302 (a)(3); Tennessee Code Annotated 33-1-303; Tennessee Code Annotated 33-1-305; Tennessee Code Annotated 33-1-309; Tennessee Code Annotated 33-2-301; Tennessee Code Annotated 33-2-408, Tennessee Home and Community Based Waivers.

II. **PURPOSE:** The purpose of this policy is to establish guidelines for applying sanctions against contracted entities due to violations of the provider agreement, provider manual, conditions of the home and community based services waivers, and departmental policies and procedures.

III. **APPLICATION:** This policy applies to department staff responsible for enforcement of the provider agreement, provider manual, authorizing and applying sanctions, and to all contracted entities.

IV. **DEFINITIONS:**

A. **Commissioner** shall mean the Commissioner of the Department of Intellectual and Developmental Disabilities.

B. **Home and Community Based Services (HCBS) waiver or waiver** shall mean a waiver approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability and who meet criteria for Medicaid criteria of reimbursement in an Intermediate Care Facility for People with Intellectual Disabilities. The HCBS waivers for people with Intellectual Disabilities in Tennessee are operated by the Department of Intellectual Disabilities (DIDD) with oversight from the Bureau of TennCare, the state Medicaid agency.

C. **Immediate Jeopardy Sanction Letter** shall mean a written document that describes the violation committed by the provider that placed the person(s)-supported in jeopardy, actions taken to ensure the safety of the person(s)-supported, and the sanction to be imposed.

D. **Mandated Technical Assistance** shall mean a requirement that a provider receive training and assistance from DIDD or secure training and assistance from a source identified by the provider and approved by DIDD.

E. **Moratorium** shall mean a prohibition on new admissions to a program or expansion of provider services.

F. **Provider Agreement** shall mean a signed agreement between DIDD, the Department of Finance and Administration, the Bureau of TennCare, and an approved provider that specifies the terms and conditions a provider must meet to receive reimbursement for services provided.

G. **Sanction** shall mean financial or other measures imposed on a provider for failure to comply with TennCare or Department of Intellectual and Developmental Disabilities (DIDD) rules, regulations, or policies.

H. **Sanction Letter** shall mean a written document that describes the violation committed by the provider, any history of action by DIDD staff to ameliorate the situation, and the sanction to be imposed.

I. **Warning Letter** shall mean a written document citing a provider for violating the provider agreement, policy, regulation, etc., and warning of the consequences of future violations.

V. **POLICY:** This policy provides a framework for consistent application of sanctions by all three (3) regional offices and central office. Sanctions shall be corrective in purpose and progressive in nature, unless the deficiency is so egregious that more severe actions are necessary to ensure immediate and appropriate correction.

VI. **PROCEDURES:**

A. General

1. Any DIDD department or unit responsible for enforcing the provider agreement and or provider manual may issue warning letters or sanction letters.
2. The DIDD department or unit that identified the violation is responsible for issuing the appropriate letter.
3. For the purposes of this policy, each regional provider operation is considered a separate entity. Warnings and sanctions against a provider operating in one region (e.g., West Tennessee) shall not automatically apply to the provider's operations in another region (e.g., Middle Tennessee).
4. Warning, sanction, and immediate jeopardy sanction letters shall be sent (e.g., email, regular mail) to the executive director of the provider agency and the board chair or agency owner, if applicable.

B. Warnings

1. A warning letter shall be issued for the first violation of the provider agreement, provider manual, departmental policy, or state or federal rule or regulation, for any situation **not designated** as an immediate jeopardy.
2. A warning letter shall describe the specific violation and the consequences of future violations.
3. All Warning letters shall be copied to the assistant commissioner of quality management, office of general counsel, director of risk management, director of provider services and supports, regional office director, chair of the regional quality management committee, the regional director of compliance, and the Bureau of TennCare.

C. Sanctions

1. A sanction letter shall be issued if a provider is cited for the same violation within 24-months of the initial warning letter.
2. A sanction resulting in ~~A~~a financial ~~sanction~~ penalty that is imposed on a "per day" basis shall remain in effect until the department receives from the provider documentation that the violation has been corrected.
3. A sanction letter shall describe the specific violation, the sanction being imposed, the history of corrective action taken prior to imposition of the sanction, and the consequences of future violations.
4. All sanction letters shall be copied to the Deputy Commissioner of Program Operations, assistant commissioner of quality management, office of general counsel, director of risk management, director of provider services and supports, director of special services, regional office director, chair of the regional quality management committee, the regional office compliance unit and the Bureau of TennCare.

Comment [CWG1]: What about: A sanction resulting in a financial penalty...that way it doesn't seem as if there is "another" category of sanctions.

Comment [JCM2R1]: Concur.

D. Immediate Jeopardy Sanctions

1. An immediate jeopardy sanction letter shall be issued for any (including the first) violation of the provider agreement, provider manual, departmental policy, or state or federal rule or regulation, and for any situation **designated** as an immediate jeopardy to person(s)-supported.
2. An immediate jeopardy sanction letter shall describe the violation committed by the provider that placed the person(s)-supported in jeopardy, actions taken to ensure the safety of the person(s)-supported, and the sanction to be imposed.
3. All immediate jeopardy sanction letters shall be copied to the Deputy Commissioner of Program Operations, assistant commissioner of quality management, office of general counsel, director of risk management, director of provider services and supports, regional office director, chair of the regional quality management committee, the regional office compliance unit and the Bureau of TennCare.

E. Central Office Sanction Review

1. The director of risk management or designee shall review all sanctions imposed on contracted providers. This review shall ensure that sanctions are imposed consistently and reliably across all regions.
2. The director of risk management shall report inconsistencies in application of sanctions to the appropriate deputy commissioner or assistant commissioner.

D. Appeal of Sanctions

1. If the provider elects to dispute the imposition of a sanction, the agency director or board chair may contact the department or unit that imposed the sanction within five (5) business days of the date on the sanction letter, and provide additional information he or she believes may affect the sanction decision.
2. Based on the evidence presented, the department or unit may rescind the sanction letter. The department or unit rescinding the sanction letter shall inform the provider of the decision within five (5) business days of receiving the additional information.
3. If the department or unit does not rescind the sanction letter, the agency director or board chair may file an appeal.
4. The following appeals process shall apply to sanctions.
    a. DIDD shall issue a sanction letter to the provider prior to imposing any sanction.
    b. The provider may appeal the sanction within ten (10) business days from the date of the sanction letter. The provider shall submit the appeal to the office of general counsel via certified mail or facsimile. The appeal shall state and explain the provider's objection(s) to the sanction.
    c. The office of general counsel shall review the appeal and route it to the Commissioner.
    d. If the provider filed the appeal within the specified time period, the imposition of monetary sanctions shall be stayed pending resolution of the appeal.
    e. The office of general counsel shall schedule a hearing in accordance with the Uniform Administrative Procedures Act.
    f. If the administrative law judge upholds the sanction, then, monetary sanctions shall be calculated from the effective date noted in the sanction letter.
    g. If the administrative law judge does not uphold the appeal, then, monetary sanctions shall not be imposed.
    h. Notwithstanding an appeal, non-monetary sanctions (e.g., mandated technical assistance) shall be applied immediately and no stay shall apply.
    i. The department shall impose financial sanctions under the following circumstances:
        1) When the time period for the provider to submit an appeal has ended without an appeal having been received from the provider.
        2) When a final order has been issued in accordance with the Uniform Administrative Procedures Act of Tennessee upholding imposition of the financial sanction.

E. TennCare Reporting Requirements

1. As specified in the department's contract with TennCare, the director of special services or designee shall submit a quarterly sanction report to the designated TennCare representative.

2. This report shall include the following information:

   a. Agency name.

   b. Amount of monetary sanction.

   c. Reason for monetary sanction (e.g., violation of provider agreement).

VII. **ATTACHMENTS:**

A. Attachment #1: Examples of Violations